Editorials

Political Philosophies and Some Realities in Health Care

HEALTH CARE is emerging as an important arena for the testing of political philosophies in the real world. A major reason for this phenomenon is the unprecedented social, economic and technologic interdependence that has developed in the field. The present-day stereotypes of liberal and conservative political philosophy, however, both seem somehow to miss the mark when it comes to the realities of health care. At the risk of oversimplification it can be said that each is rooted in a fundamental tenet of American belief: Liberalism has a basis in the belief that all men are created equal—which has led to increasing manifestations of egalitarianism, such as anti-intellectualism and antiprofessionalism. Conservatism is rooted in the belief that, by dint of hard work and a little luck, one can advance in this world and is then entitled to its rewards—that is, one is entitled to have what one can pay for. This necessarily leads to elitism expressed in various ways. These beliefs appear to be in fundamental conflict and this has become readily apparent in the field of health care where elitism (professionalism) and egalitarianism (antiprofessionalism) are often at odds.

These two political philosophies are joined in the issues of quality, access, costs and control of health care. The one calls for equal access to high quality health care for all, and the other for different levels of care depending upon who can afford what. It is likely that costs of care will defy the approach of either political philosophy. The one has already driven the costs beyond the acceptable reach of society, and the other will never be able to deny care to those who really cannot afford it. And the one would centralize control of health care by nationalizing it under federal regulation, but this would not work because centralized regulation has already been shown unable to keep pace with the rapid changes that occur in health care. And the other would deregulate the health care system, but in the process of doing this is finding it necessary to place restrictions hampering and sometimes even destroying the internal controls that have been developed in the private sector to bring some kind of order into a dynamic and ever-changing system with many essential yet interdependent parts.

It is clear that issues of access, quality, cost and control are not likely to be resolved simply by applying either stereotyped political philosophy. Health care is not an abstract concept that can be dealt with by abstract philosophical approaches. Health care is a reality that touches the lives and well-being of people. It is likely that it is the political philosophies that are unreal when it comes to health care and this may be because neither of the stereotypes addresses the reality of the conflict of fundamental beliefs that is coming into focus around issues in health care.

It would seem that both these major political philosophies will need to find a genuine accommodation in health care. The realities of human needs which are very personal, costs which are less personal, and the nature of a highly specialized and technologic, social, economic and politically interdependent health care system which is relatively impersonal, require that an accommodation be sought. Perhaps it is time to return the problem to the people, to return the responsibility for collaboration and for the control of health care to local communities or regions. It could be valuable to allow the decisions about access, quality, costs and controls to be made by those who need health care and those who can provide it—where fundamental beliefs that may be in conflict can be accommodated to the real problems at hand.

—MSMW

Advances in Obstetrical Technology

A NUMBER OF IMPORTANT ADVANCES have occurred in obstetrics in the past few decades, but the most dramatic must surely be those concerned with the detection of a fetus in difficulties.

The potential hazards that can now be detected fall broadly into two categories: (1) in utero inadequate growth and asphyxia and (2) structural, biochemical or physiologic defects. Over the years a number of clinical and laboratory methods have been proposed as techniques of fetal surveillance. There was a period when the multiplicity of tests created a good deal of confusion—particularly in the former category—but the situation is now stabilizing, though many of the proposed tests have been discarded. The authors of the Medical Progress article in this issue highlight three approaches that are emerging as the most effective in detecting a fetus with problems: amniocentesis, beat-to-beat fetal heart rate monitoring and ultrasound imaging.

The emphasis placed on these sophisticated methods should not be taken to indicate that the cheaper clinical screening approaches have no value. For example, the prime means of screening for and detecting most growth-retarded fetuses remain serial measurements of fundal height with a tape measure. This has been shown to be effective in detecting up to 80 percent of growth-retarded fetuses if there is inadequate fundal growth during a three- to four-week period in the third trimester.[1]

Some researchers have proposed screening the entire population with either hormonal measurements (for example, maternal estriol or human placental lactogen) or ultrasound measurements. This has not gained widespread acceptance, primarily because the procedures do

not fit the criteria for screening tests, such as low cost, lack of false-negative results and ease of performance.

The use of "high risk" categorization in both the antepartum and intrapartum periods is still a valuable aid in signifying those pregnancies in need of more attention and further testing by more specific methods. A defect with this screen, however, has become obvious in recent years, in that even a low-risk woman may have an adverse reproductive outcome.[2] Two major categories in such patients are antepartum stillbirth and asphyxial morbidity during labor. A possible screen for antepartum stillbirth is fetal movement counting, which is now widely accepted in Britain and elsewhere, but which has been struggling to gain respectability in North America. The publication of extensive clinical trials of its efficacy should ensure its acceptance and usage.[3]

Antepartum fetal heart rate monitoring has been proposed as a screen in all patients, but this has not been widely accepted. The major reasons include cost, difficulty of timing in relation to the morbid event and proof that its benefit will outweigh the risks. The major risk includes high false-positive rates, that is, a large number of fetuses with "abnormal" results by current criteria are in fact quite normal. Such false-positives may precipitate unnecessary intervention. The addition of other observations, such as fetal movement, may help to diminish the problem.

Intrapartum fetal heart rate monitoring is still plagued by inappropriate interpretation in some hands, despite a growing understanding through experimental studies of the physiologic meaning of various aspects of fetal heart rate patterns during asphyxia. More facts are needed, however, regarding the origin and significance of fetal heart rate variability and its relationship to cerebral and myocardial oxygenation. Also, continued education of an obstetric team is required to keep all up to date with recent progress. Despite its drawbacks, fetal heart rate monitoring is likely to remain the prime screen for intrapartum asphyxia for decades to come.

Ultrasound imaging is widely used for gestational age dating, but a rarely mentioned defect is the variance of the measurement in clinical usage. This is most likely due to the absence of uniformity of criteria, variation in populations and relative lack of expertise. Most published reports are by skilled investigators from research institutions, and this gives an unnecessarily optimistic view of its accuracy. In clinical usage, gestational age can at best be determined to within about two weeks at any stage of gestation. The variation imposes grave difficulties in accurately detecting changes in cases of suspected growth retardation. As with fetal heart rate monitoring, however, improvements can be expected by such approaches as better education and improved criteria.

Several conclusions emerge from a consideration of the newer technology in obstetrics: (1) A careful clinical history and examination are still important, (2) cheap clinical screening techniques remain the basis of good obstetrical practice and (3) the sophisticated tests potentially abound with "false abnormal positives," and require knowledgeable interpretation in light of the whole clinical case.

JULIAN T. PARER, MD, PhD
Professor and Director of Obstetrics
Department of Obstetrics,
Gynecology and Reproductive Sciences
Associate Staff
Cardiovascular Research Institute
University of California, San Francisco

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A Mantle of Leadership

IT SEEMS THAT circumstances beyond its control have unexpectedly thrust a mantle of leadership upon the shoulders of the California Medical Association (CMA). A revolution in the way medicine is practiced has begun in California as a result of the so-called contracting legislation which was hurriedly enacted by the California legislature and signed by the governor in the summer of 1982, without any of the customary public hearings or any chance for comment by patients, physicians or others who might be affected by it. As a result, new and untested practice arrangements are coming into being. The nation is watching what happens in California and the nation's physicians are watching to see how well the CMA wears this mantle of leadership which it neither sought nor wanted.

A sharp interaction of social, economic and political forces is occuring. The long-standing social goal of equal access to needed health care of good quality continue to be supported by the medical profession and many others, but the cost of this is being seriously challenged by government and others who have been paying the bills. The currently ascendant economic theory contends that health care costs can be contained if the economic forces of the free market can be brought into play. In a word this means competition. Rulings by the United States Supreme Court and the Federal Trade Commission, as well as a number of federal antitrust actions, have already given substantial endorsement to this approach. And in the summer of 1982 the California legislature, confronted by a fiscal crisis in health care, decided to mandate competition. As someone has put it, the laws that were passed make it possible for doctors and patients to be bought and sold like commodities at discounts and to the lowest bidders. Contracts and contracting for health care are now the order of the day in California. No one knows whether the economic theory is correct, whether mandating competition (for California's Title XIX program, known as Medi-Cal) and making it permissible for other programs in the private sector, will work. And no one knows what effect all this will have on the social and